**AGENDA ITEM NO. 5**

# CHILDREN & YOUNG PEOPLE'S SOCIAL CARE & LEARNING SCRUTINY PANEL

## 11 DECEMBER 2018

## Public Health South Tees


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### 1.0 SUMMARY


This report provides an overview of the functions of the Public Health South Tees Service with a particular focus on the services which are delivered and commissioned by Public Health which have a direct impact on the Early Help agenda. The report will provide information on the following delivered and commissioned services, The Maternal, Infant and Child Health Partnership, Head Start, The Middlesbrough Healthier Together Service (Healthy Child Programme) and Change, Live, Grow (CGL).


### 2.0 INTRODUCTION

South Tees contains 17 wards that are within the top 10% most deprived wards nationally, experiencing many of the issues that run in tandem with deprivation such as high unemployment, poor population health, high than national average levels of substance addictions, low household incomes, high rates of crime and anti-social behaviour, high numbers of children in care and significant numbers of children living in poverty.

Middlesbrough has a higher proportion of Black, Asian, and Minority Ethnic (BAME) population (11.8%) compared to the North East average of 4.7%. This brings its own challenges due the potential cultural and language barriers this population group face which can result in them not accessing support and services which are needed, widening further the health inequalities.

On the 1st April 2018 we established Public Health South Tees, the joint service aligned to both Middlesbrough Council and Redcar & Cleveland Borough Council. This brings together skills and experience of a large team which aims to:

- Reduce local health inequalities
- Promote the health and well-being of the population
- Protect the residents of South Tees from health harms
- Support our residents to live longer and healthier lives
- All our children to benefit from the best start in life

**3.0 Maternal Infant and Child Health Partnership**

**3.1 Introduction**

Heath inequalities for many children and young people across South of Tees begin from pre-conception and follow them throughout their life course. There is strong evidence that investing in early intervention, prevention and support as early as possible leads to significant savings across public services.

Babies born today are expected to live on average 3.6 years less than the England average in Middlesbrough and 1.6 years less in Redcar and Cleveland. However the inequality gap within the local areas of Middlesbrough and Redcar and Cleveland is even more significant. Two male babies born on the same day in South Tees could have as much as a 12 year difference in life expectancy due to the circumstances into which they are born.

The Maternal Infant and Child Health Partnership was established by Public Health following the 2012 National Health Service (NHS) reforms, which resulted in fragmented commissioning and delivery of maternal and infant services.

The partnership's vision was to develop a strategic, overarching vision and delivery plan for the commissioning and delivery of public health services which impact on maternal and infant health outcomes ensuring a co-ordinated and joined up approach across organisations and commissioning structures with led to increased early intervention and prevention.

**3.2 What the partnership does in terms of prevention and early help**

Despite the hard work across South Tees to tackle this agenda there remains a significant set of factors which increase a child's risk of poor life chances. To reduce the impact of these risk factors the partnership consists of a wide range of key partners from early years services, maternity services, The Healthy Child Programme, South Tees Clinical Commissioning Group and Public Health. The structure consists of a strategic board and several subgroups following the recommendations of the 6 high impact areas:

- Maternal smoking

- Healthy weight
- Maternal substance misuse
- 1001 days (including development of a child aged 2)
- Maternal substance misuse
- Infant feeding

Driven by Public Health South Tees, MICH has been instrumental in driving improvements to maternal and early years support in South Tees, challenging partners in the sector to work together to achieve more. Some of the successes of the partnership include:

- **737 LESS women smoked during pregnancy** - This means that in South Tees we will have less still births, less children born with breathing, feeding and health problems and less children with asthma and other serious illnesses in later life

- **Professionals collaborated more thanks to MICH** - Professionals now work more closely together than ever, co-producing and delivering support in a more efficient way. This means that more families get focussed support at the right time.

- **Women are screened for alcohol use during pregnancy and get immediate early support** - This reduces the chances of children born in South Tees who are at risk of growing up with social and emotional difficulties, ending up in the social care system and the criminal justice system in later life, which are common for children exposed to alcohol during pregnancy. FASD training has also been rolled out

- **Significant increase in referrals to talking therapies** - Talking therapies develops positive mental health. For parents this is pivotal, babies born to those with poor parental mental health and emotional wellbeing often experience delays in development whereas children with good mental health and emotional wellbeing are much more likely to thrive.

- **Development delays are identified at the earliest possible point so children get support earlier to help them start school on an equal footing with peers -** Children are screened using Ages and Stages Questionnaires so that they get extra support early, getting school readiness support where identified

- **Healthy Weight** – Supported the ongoing commissioning of the Healthy Lifestyles Clinic for women with a Body Mass Index over 40 at booking and the roll out of the weight gain in pregnancy charts for all women accessing maternity services at South Tees Hospitals NHS Foundation Trust.

- **Introduced Pregnancy Birth and Beyond** which is delivered jointly by Midwives, Health Visitors and Early Years practitioners.

- **Infant feeding** leads now in place across South Tees and we have a wide spread campaign to normalise breastfeeding.

The success of the partnership stems from its ethos of collaboration and encouraging partners to work together to achieve more. In the last three years (2015-18) MICH has driven improvements to local maternal, infant and child health services thanks to all those involved. This has seen expectant and new parents in South Tees get better quality support at a time in their life time where it is needed the most.

## 4.0 Head Start

### 4.1 Introduction

In 2015 the Government's *Future in Mind (FiM)* report was published, providing national recognition of the need to make dramatic improvements in children's mental health services. The report highlighted that although the needs of young people continue to rise investment and services are insufficient in meeting demand. The report set out five key themes that could enhance a systemic changed approach to improve children's emotional wellbeing:

- Promoting resilience, prevention and early intervention
- Improving access to effective support system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Local areas were challenged to achieve this systemic change by 2020.

Middlesbrough has the highest levels of children and young people's emotional and mental disorders in England. It is estimated that 3 pupils in every classroom will develop a diagnosable emotional or mental health disorder. Most adults with a diagnosable condition had developed this by the age of 14.The Early Intervention Foundation (2015) (EIF) states damaging social problems affecting children and young people such as mental health problems, costs the Government almost £17 billion a year. An estimated further £4 billion a year is spent on benefits for 18-24-year-olds not in education, employment or training (NEET) with another £900 million spent helping young people suffering from mental health issues or battling additions. These figures only represent the immediate cost in a single year, and do not capture the longer-term impact which can last into adult life and sometimes impact on the next generation. The EIF analysis shows council services are having to pick up the largest share of the national late intervention spend into the next generation.

### 4.2 Achieving Systemic Change

A local programme of transformation had already commenced in 2014 following a £1 million Big Lottery grant awarded to develop a local approach to support the emotional and mental health of children and young people at an early stage. This funding was invested in testing a new model of support in school, the home, the community and through digital solutions.

Following the end of the Big Lottery grant, FiM, Public Health and Middlesbrough Achievement Partnerships funding was allocated to roll out the tested model and to facilitate wider systemic and sustainable change, working in partnership to commission differently, sharing resources and budgets, co-producing new delivery models with young people and key stakeholders and effectively sharing vital information.

To achieve this ambition a multi-sector board was established. The HeadStart/Child and Academic Mental Health Service (CAMHS) Transformation Board now has designated responsibility from the Children and Young People's Trust to lead on children and young people's mental health. A number of subgroups have been established to develop specific areas of work. Strong links and shared arrangements have been developed with Middlesbrough Achievement Partnership and the Prevention and Partnerships board. A programme team, comprising a programme manager, programme officer, school development officer and communication and engagement apprentice manage the transformation programme and discharge a mix of strategic and operational duties.

**4.3 Current Delivery**

The transformation model is predicted on the following principles –

- Employing the Resilience Framework to build upon the assets of the children and young people.
- A commitment to co-production with children and young people, their families and communities.
- Sustainability to create a lasting change.

**School –** A local quality standard has been developed to facilitate a whole school approach; evidencing emotional well-being and mental health is a key priority from policy to practice, governors to classroom staff. Key features of school transformation are as follows –

- Workforce development to upskill staff to better understand and cope with pupil emotional and mental health.
- Emotional well-being practitioners in all schools providing universal support at an early stage.
- Transition support for years 6 – 7 and years 11 – 12.
- Accredited training to create HeadStarter pupil mental health champions.
- A single referral point for emotional wellbeing practitioners, CAMHS clinicians and school nurses, is currently in development. This will establish an integrated pathway of support.

**Post 16 –** work is underway with 6th form and further education colleges to introduce the HeadStart model. This is progressing well with all colleges engaging in the process.

**Community –** Extensive community consultation has been undertaken to identify an appropriate and viable model to provide support within community settings. Big Lottery have encouraged a grant application and this will be submitted in late November 2018. Family drop-ins have been established in a community setting during school holidays to prevent problems escalating when young people do not have the security and routine of school.

**Pre – 5 –** Work has commenced in partnership with Harrogate and District and Tees, Esk and Wear Valley NHS Trusts to better upskill parents and pre-school settings in infant and child mental health. To date this has included the provision of specialist training to all health visitors.

**4.4 Outcomes**

Transformation is well developed in schools with all schools in receipt of HeadStart support and services. The Reach Partnership is commissioned by the HeadStart Programme Board to provide therapeutic services. Between April 2016 and May 2018 833 school referrals for early help were made. Reported improvements in emotional well-being for pupils receiving support were positive; those under the age of 6 reported a 100% improvement, 6 to 11 year olds between 92% and 100% and 11 to 16 years olds between 90% to 92%. Similarly improved outcomes were reported for anxiety, anger and conduct.

- Over 35 schools have accessed training specifically related to pupil mental health. This includes academic resilience training which complements restorative practice.
- HeadStarter youth mental health champions have been recruited in 32 schools with 250 guided learning hours delivered. This is the first accredited pathway for youth mental health champions in the country. The first accreditation has been achieved by a group of primary pupils.
- TEWV CAMHS have reported a dip in referrals for specialist support which they attribute to the introduction of HeadStart early help support in schools. School referrals by schools over the last 3 years have been –
- 2015/2016 - 2,600
- 2016/2017 - 1,400,
- 2017/2018 - 1,700.

This equates to non-recoverable savings of £600,000. This is against the trend in neighbouring local authority areas. TEWV are redirecting savings into early help provision which includes providing additional staff resource to the HeadStart delivery in schools.

The HeadStart team has developed good working relationships with the Family Partnership team supporting implementation of My Family Plan. HeadStart is recognised at best practice within the Early Help Strategy.

There has been regional interest in HeadStart which has resulted in opportunities for collaboration. The HeadStart Programme Manager has been appointed as a Department of Education Regional System Lead for mental health in schools following a recommendation from the Middlesbrough Teaching Alliance. This position will entail supporting schools across the region.

The HeadStart programme will benefit 16,431 school age and further education pupils through a preventative and early intervention approach.

## 5.0 Change, Live, Grow (CGL)

### 5.1 Introduction

Change, grow, live (CGL) are providing the psychosocial treatment aspect of the MRT model for both adults and young people, adopting a whole family approach wherever possible. Their model provides a clear recovery pathway ensuring service users and partners experience the journey as a single treatment system. Harm minimisation, prevention, early intervention and specialist recovery interventions form core elements of the service, underpinned by evidence-based screening tools, assessment and care co-ordination processes that focus on strengths and aspirations - both from individual and family perspectives. All treatment packages offered are to be individually tailored with recovery embedded from the offset.

### 5.2 What it does in terms of prevention and early help

Figures published by PHE (2018) below show that there are a high number of parents with substance misuse issues living with children in Middlesbrough. Whilst we do perform better in terms of engaging parents in treatment, there is still a cohort we are not reaching.

*Table 1: Annual met treatment need estimates, opiate dependency 2014/15 to 2016/17*

| **Adults with an opiate dependency** | **Middlesbrough** | | | **Benchmark** | **National** |
|---|---|---|---|---|---|
| | *Prevalence* | *Treatment* | *% met need* | *%* | *%* |
| The number of women with a dependency who live with children | 240 | 176 | 73% | 52% | 60% |
| The number of children who live with a woman with a dependency | 436 | 401 | 92% | 55% | 60% |
| The number of men with a dependency who live with children | 537 | 312 | 58% | 45% | 48% |
| The number of children who live with a man with a dependency | 1017 | 718 | 71% | 47% | 49% |
| Total number of adults with a dependency who live with children | 777 | 488 | 63% | 48% | 52% |
| Total number of children who live with an adult with a dependency | 1453 | 1119 | 77% | 50% | 53% |

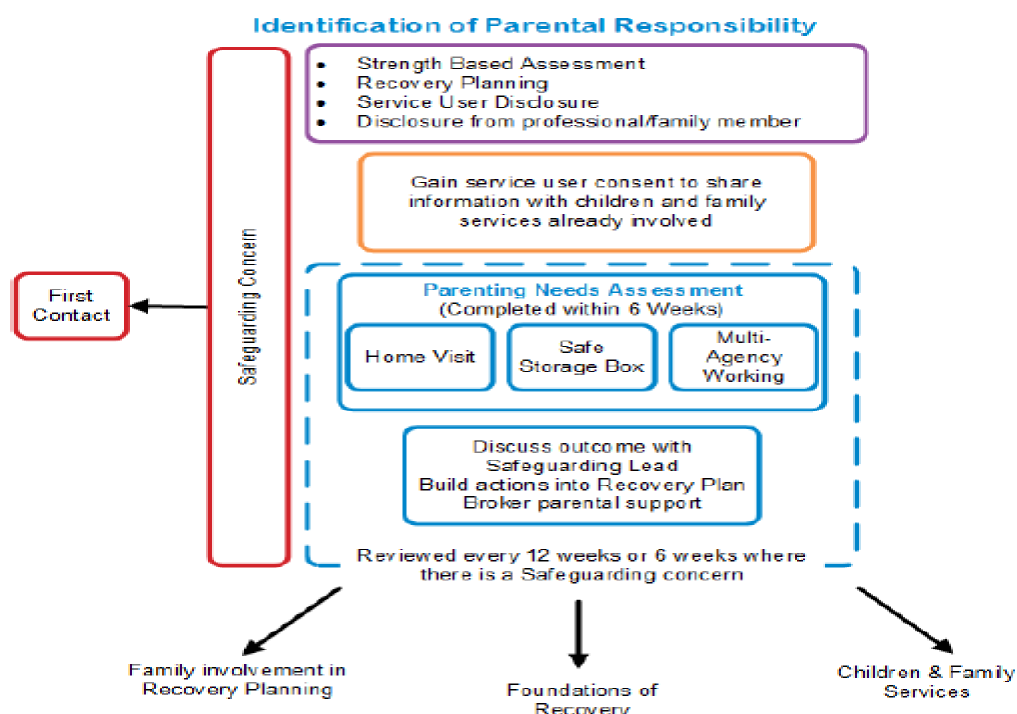
A whole family approach is taken within MRT, right from treatment entry, where data is collated around parental status, contact with children, living situation etc. All this is then risk assessed in terms of the impact of a parents substance misuse on the child. The data set below from PHE (2018) details the results of treatment entry screening.

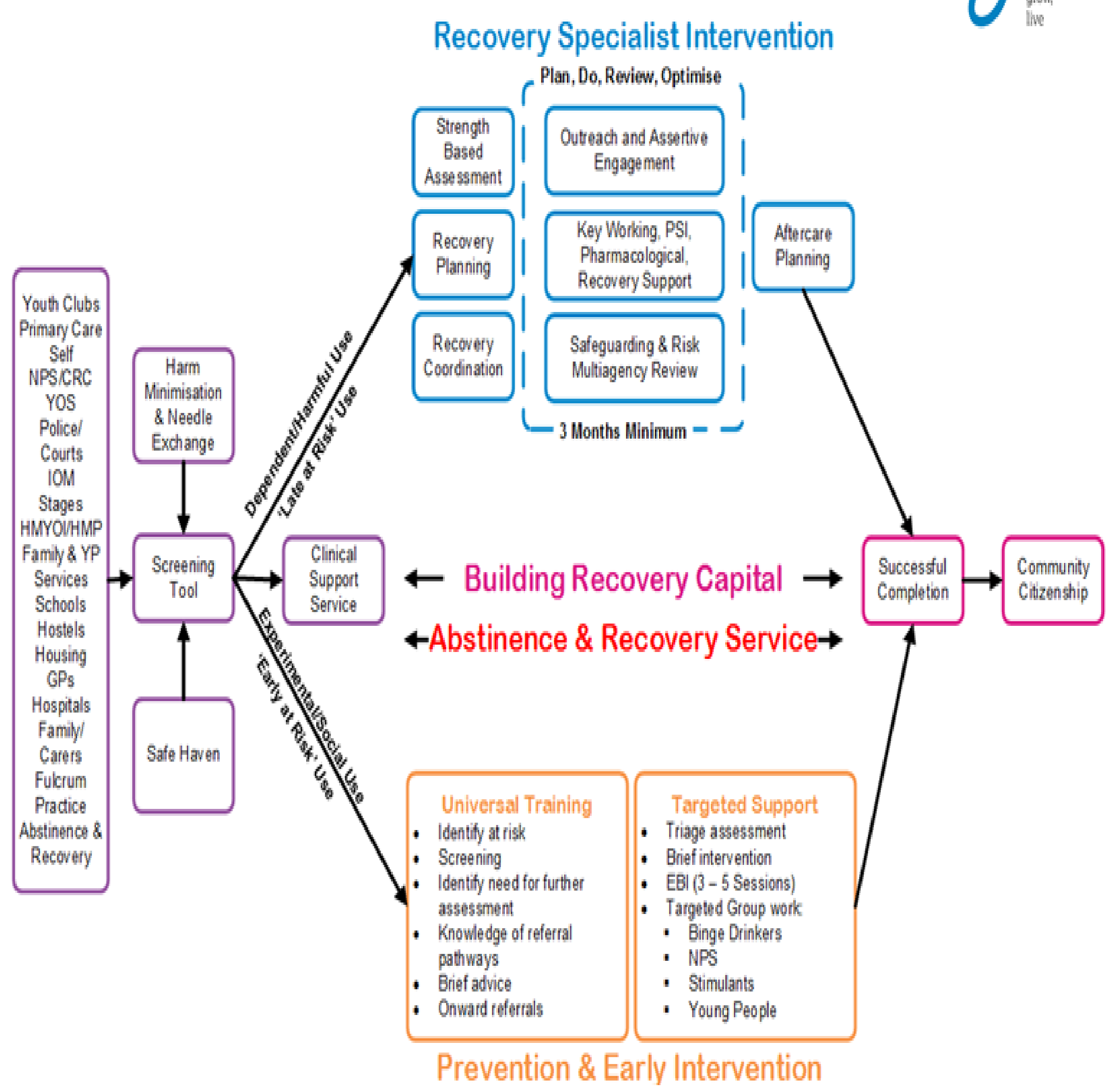
| Parental status | Local n | Proportion of new presentations | Proportion by gender M | Proportion by gender F | National n | Proportion of new presentations | Proportion by gender M | Proportion by gender F |
|---|---|---|---|---|---|---|---|---|
| Living with children (own or other) | 92 | 17% | 14% | 29% | 13,626 | 18% | 14% | 27% |
| Parents not living with children | 225 | 42% | 44% | 36% | 25,946 | 34% | 34% | 34% |
| Not a parent/no child contact | 214 | 40% | 42% | 36% | 36,623 | 48% | 51% | 38% |
| Missing / incomplete | 1 | 0% | 0% | 0% | 456 | 1% | 1% | 1% |
| **Living with children** | **Local** n | | Proportion of children by client gender M | Proportion of children by client gender F | **National** n | | Proportion of children by client gender M | Proportion of children by client gender F |
| Number of children living with drug users entering treatment in 2017-18 | 212 | | 60% | 40% | 25,205 | | 61% | 39% |
| **Clients' children receiving early help or in contact with children's social care** | **Local** n | **Proportion of clients with child contact** | Proportion by gender M | Proportion by gender F | **National** n | **Proportion of clients with child contact** | Proportion by gender M | Proportion by gender F |
| Early help | 10 | 3% | 1% | 8% | 920 | 2% | 2% | 4% |
| Child in need | 15 | 5% | 3% | 11% | 1,111 | 3% | 2% | 5% |
| Child protection plan in place | 23 | 7% | 7% | 7% | 2,975 | 8% | 5% | 13% |
| Looked after child | 8 | 3% | 2% | 5% | 2,115 | 5% | 3% | 10% |
| **Pregnancy data** | n | **Proportion of new female presentations** | | | n | **Proportion of new female presentations** | | |
| New female presentations who were pregnant | 8 | 6% | | | 896 | 4% | | |
| Missing / incomplete | 35 | 27% | | | 596 | 3% | | |

Following the initial assessment process, if it is identified that there are children in the household, a home visit will be carried out by the care co-ordinator. This is an opportunity to observe children and assess their environment within the family home, to inform the Parental Capacity Assessment (PCA). Upon completion of the PCA, the RC will discuss the outcome with CGL's Safeguarding Lead and actions are built into the SU's Recovery Plan. The staff have all underwent the training for the 'My Family Plan' document, and this will be completed by the MRT staff member working with the family.

- The pathway for working with families

The diagrams below detail the process for identifying families and assessing risk, and also the adult care coordination pathway that will be followed with parents, but with some tailored elements taking into account their living situation and needs as a whole family:






### 5.3 Benefits to Early Help

In order to ensure the work MRT is doing with families is aligned to Early Help, a Senior Practitioner role is in place that works across both MRT and Early Help has been in place for the last three years. This role is in place to ensure that families are picked up and supported at the earliest opportunity, and that working with both services is seamless, with information shared across both systems where needed. Whole family interventions are delivered that involve the children and parents- MPACT and Parent Factor, which are both evidence based interventions that are specifically designed for substance misusing parents.

The role carries a caseload of families that need parenting interventions, and also some substance misuse support. The work carried out is done alongside any interventions deemed appropriate by Early Help. There is also a developmental aspect to the role that centres on the upskilling of MRT staff in Early Help pathways and processes. Meaning that there is resilience built into the model by staff all having a full understanding of Early Help, and how to ensure the client understands the benefits of such work.

The role also works alongside the Safeguarding Lead for the CGL service, and will often work together to discuss cases and decide on next steps for a family where needed. The benefits of both these roles are that it has increased staff confidence in taking a whole family approach, while also improving the assessment processes followed at treatment entry.

The roles are also helping with the sharing of information between both services, with the Senior Practitioner role getting access to Capita imminently.

## 6.0 Healthier Together (0-19 Healthy Child Programme)

### 6.1 Introduction

Our Healthier Together Middlesbrough 0-19 Service (Harrogate and District NHS Foundation Trust) provides a strong evidence based universal offer of core contacts, mandated by the Department of Health, leading to early identification of needs and provision of early intervention, enhanced offer and early help through both single agency and wider multi- agency interventions.

Our Healthy Child Programme delivery is core to meeting the Middlesbrough Strategic Public Health Priorities:

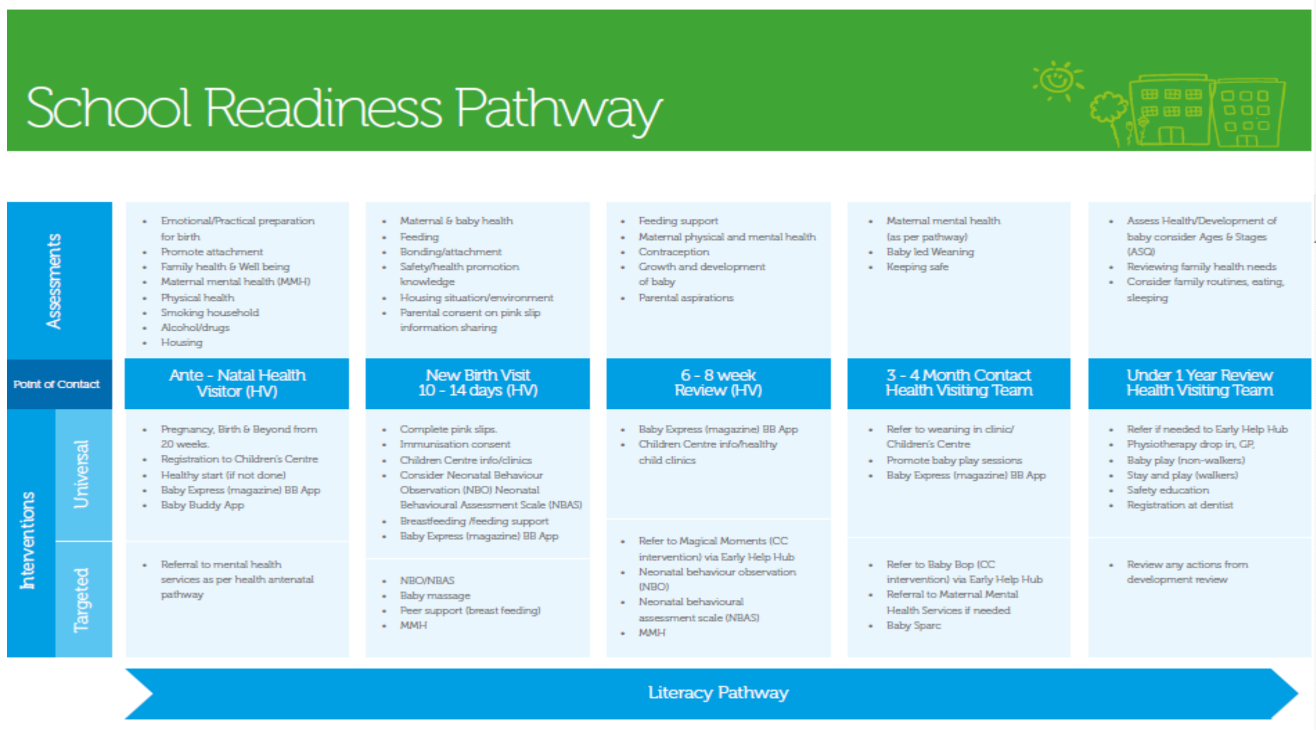
- All children benefit from a healthy pregnancy
- All children thrive and meet their developmental milestones
- Reducing the impact of risk taking behaviour on Children, Young People and Families
- Children and Young People have good emotional health and wellbeing.
- 0-19 Health Visiting and School Nursing teams are uniquely placed to engage and empower families and build trusting relationships. The Healthy Child Programme provides a collaborative framework to support partnership working and improving on integrated delivery and early help for children and families.

The focus of health visiting, an advanced and specialist public health nursing service, is the whole population of children in the foundation years (from pregnancy to age five). In particular, health visitors engage on a universal basis with the families of all children in the first ‘1001 critical days’ from conception to age two. This is described as the ‘age of opportunity’ (WAVE Trust, 2014) when the impact of social and other adversity can become biologically embedded in brain development – showing in a child’s social, emotional, cognitive and physical developmental outcomes.

### 6.2 What it does in terms of prevention and early help

The Healthy Child Programme (HCP) is an evidence-based framework for the delivery of public health services to families from conception to age 19 (25 for SEND). This is a universal prevention and early intervention programme and forms an integral part of Public Health England's priority to support healthy pregnancy, ensure children's early development and readiness for school, and reduce health inequalities in young children and teenagers.

Using key mandated contacts as per Healthy Child Programme in Middlesbrough "The Healthier Together" services provide a consistent framework for delivery of Early Years Services and the opportunity for closer partnership working through an integrated school readiness pathway.



School Readiness Pathway

| Point of Contact | Ante - Natal Health Visitor (HV) | New Birth Visit 10 - 14 days (HV) | 6 - 8 week Review (HV) | 3 - 4 Month Contact Health Visiting Team | Under 1 Year Review Health Visiting Team |
|---|---|---|---|---|---|
| Assessments | • Emotional/Practical preparation for birth<br>• Promote attachment<br>• Family health & Well being<br>• Maternal mental health (MMH)<br>• Physical health<br>• Smoking household<br>• Alcohol/drugs<br>• Housing | • Maternal & baby health<br>• Feeding<br>• Bonding/attachment<br>• Safety/health promotion knowledge<br>• Housing situation/environment<br>• Parental consent on pink slip information sharing | • Feeding support<br>• Maternal physical and mental health<br>• Contraception<br>• Growth and development of baby<br>• Parental aspirations | • Maternal mental health (as per pathway)<br>• Baby led Weaning<br>• Keeping safe | • Assess Health/Development of baby consider Ages & Stages (ASQ)<br>• Reviewing family health needs<br>• Consider family routines, eating, sleeping |
| Interventions – Universal | • Pregnancy, Birth & Beyond from 20 weeks.<br>• Registration to Children's Centre<br>• Healthy start (if not done)<br>• Baby Express (magazine) BB App<br>• Baby Buddy App | • Complete pink slips.<br>• Immunisation consent<br>• Children Centre info/clinics<br>• Consider Neonatal Behaviour Observation (NBO) Neonatal Behavioural Assessment Scale (NBAS)<br>• Breastfeeding /feeding support<br>• Baby Express (magazine) BB App | • Baby Express (magazine) BB App<br>• Children Centre info/healthy child clinics | • Refer to weaning in clinic/ Children's Centre<br>• Promote baby play sessions<br>• Baby Express (magazine) BB App | • Refer if needed to Early Help Hub<br>• Physiotherapy drop in, GP,<br>• Baby play (non-walkers)<br>• Stay and play (walkers)<br>• Safety education<br>• Registration at dentist |
| Interventions – Targeted | • Referral to mental health services as per health antenatal pathway | • NBO/NBAS<br>• Baby massage<br>• Peer support (breast feeding)<br>• MMH | • Refer to Magical Moments (CC intervention) via Early Help Hub<br>• Neonatal behaviour observation (NBO)<br>• Neonatal behavioural assessment scale (NBAS)<br>• MMH | • Refer to Baby Bop (CC intervention) via Early Help Hub<br>• Referral to Maternal Mental Health Services if needed<br>• Baby Sparc | • Review any actions from development review |

Literacy Pathway

It is understood that health has an integral statutory role with supporting children and families. Developing a model in line with the Healthy Child Programme will set out key contact, assessment and intervention points that can be used as measures of school readiness at the earliest opportunity.

| | | | | | | |
|---|---|---|---|---|---|---|
| Assessments | | • Eligibility for 2 year entitlement<br>• Work ready skills of parents<br>• Aware of 3yr Nursery Education Grant (NEG) | • Review Health/development as per ASQ3<br>• Health promotion as per Healthy Child Programme<br>• Review uptake of A2YO place<br>• Promote positive strategies around behaviour | • Health and development review for targeted children | • Checklist based on nursery readiness agreements<br>• Data shared with Local Authority | • Health review as per healthy child programme<br>• Handover from health visitor to school nurse |
| int of Contact | | 18-24 month (Children's Centre) | 24-27 month review ASQ Health Visiting Team | 3 year health review Health Visiting Team | On entry to nursery baseline 3 year | EYFS Assessment 4 year |
| nterventions | Universal | • Support & encourage take-up of A2YO place<br>• Promote dental health, healthy diet & weight<br>• Check registration at Children's Centre & dentist<br>• Discourage use of dummies/bottles<br>• Promote/signpost to family learning & parenting | • Appropriate referrals as needed re health depending on score of ASQ e.g. SALT, Cleveland Unit<br>• Appropriate health/development referrals as needed depending on score of ASQ<br>• Liaise with nursery provider<br>• Signpost to family learning/ parenting programmes | • Information, advice & guidance (IAG)<br>• Signposting to family learning/ parenting programmes | • Specific intervention as per school offer | |
| | Targeted | • A2YO/IAG transition<br>• Refer to Early Help Hub (family support, parenting 1:1)<br>• Information, advice, guidance around Achieving 2 year old offer (A2YO) | • Refer to Bookstart Story Corner via Early Help Hub<br>• Early Help Hub (family support, parenting 1:1) | • Health & development of child review (ASQ)<br>• Early Help Hub (family support, parenting 1:1) | • Early Help Hub (family support, parenting 1:1) | • Early Help Hub (family support, parenting 1:1) |

Literacy Pathway

Some examples of Early Help Support offered by Healthier Together 0-19 Service:

- Single Point of Contact (SPOC)- 0-19 Healthier Together has a SPOC to facilitate ease of access for initial contacts for young people, parents, schools and key partners. We are currently undertaking an audit of calls to establish reasons for calls to our SPOC, and which of these are requests for Early Help.
- Duty System- we have 9-5 cover by a Health Visitor and School Nurse via a duty system to ensure a timely and efficient response to requests for advice, support, and information sharing to support assessment and analysis of risk.

Through the universal contacts we deliver, many issues are picked up and addressed before they reach the early help service through access to an enhanced offer from 0-19 delivered by skill mix within the team, taking the lead professional role to coordinate additional support through my Family Plan, alongside referrals to specialist services. Examples of the help we provide:

- Pregnancy Birth and Beyond
- Breast feeding support
- Perinatal Mental health screening/Listening visits
- Solihull online parenting module

- Behaviour management
- Sleep management
- Health promotion community activities
- Promoting and Managing Healthy Weight
- Community Nurse Prescribing
- Stop Smoking Brief Intervention and Intermediate Support
- Making every contact count
- Unintentional Childhood Injuries Follow Up Pathway.

**6.3 Integrated Early Help Pilot**

Public Health have invested monies into a 12 month project, which aims to drive integrated working practices by improving joint working between local authority Early Help and the Middlesbrough Healthier Together service. At present both services are unable to fully meet demand and it is becoming more difficult to develop service model that satisfies the needs of the Middlesbrough population. Consequently services need to bring resource together so that they are more efficient and effective for residents.

Areas of need have been identified that are essential to both services working together better, with joint pathways and joint assessments being the main two areas. During the course of the year two nurses will be working on developing a joint pathway (Early Help and the Middlesbrough Healthier Together service) between for those that need extra support during pregnancy and early years and also a holistic Health needs assessment that will tie in with Middlesbrough Early Help Assessment.

The role within the Stronger Families team aims to lead forward key areas of practice development which include the implementation of a Vulnerable Parenting Pathway, the development of a robust Family Health Needs Assessment and the implementation of a Home Environment Assessment Tool pilot (For more information see Appendix 1). Within this role staff training will be pertinent specifically in relation to the Solihull Approach and Trauma. This role represents the 0-19 service at Early Help Forums and is the link between the Family Partnership Team and the 0-19 service. The role will also further develop to support the ACE pilot which is an imperative for the Middlesbrough Children's Trust.

The role within the Family Case work team will be leading casework pertinent to Emotional Health within family units and utilising the Solihull Approach in relation to

interventions. This role is an advisory role for staff within the Stronger Family Team and the 0-19 service. This role is supporting the 0-19 service with the completion of My Family Plan's to increase uptake which should have a positive impact on the care delivery for the family's in Middlesbrough. To participate in the ACE pilot.

### 6.4 0-5 Data October 2018

The table below shows the caseload of 0-5 children that the service is working with in relation to the level of intervention which is required. At Universal Plus and Partnership Plus level the service will be providing early help interventions.

| October 2018 | Definition | 0-5 caseloads<br><br>Children |
|---|---|---|
| Universal | Universal services from the health visitor team working with general practice to ensure that families can access the Healthy Child Programme , and that parents are<br><br>supported at key times and have access to a range of community services | 7317 |
| Universal Plus | Single Agency Response<br><br>Universal plus offers rapid response from the local health visiting team when<br><br>specific expert help is needed for example with postnatal depression, a sleepless<br><br>baby, weaning or answering any concerns about parenting | 673 |
| Universal Partnership Plus | Multi agency response<br><br>Universal partnership plus provides ongoing support from the health visiting team<br><br>and a range of local services to deal with more complex issues over a period of time.<br><br>These include services from Sure Start Children's Centres, other community services<br><br>including charities and, where appropriate, the Family | 326 |

| | | |
|---|---|---|
| | Nurse Partnership | |
| Child Protection | Multi agency response<br><br>Children Subject to a Child Protection Plan. | 99 |

Appendix 1

**Family Health Needs Assessment (FHNA)**

A robust FHNA provides the foundation for delivery of care to meet child and family needs, and facilitate good risk analysis and using a strengths based approach. Following consultation with staff, the FHNA tool development will incorporate:

- Completion at first contact and then reviewed at each new contact.
- FHNA to be the same across 0-19 service, as currently family information is not collected in school health record.
- Can be completed on one family member and populated across other family members (like change of address can be done)? To reduce duplication of work across family records.
- Family health history/ Medical history, including allergies. Disabilities.
- Smoking /alcohol/ drugs
- Domestic Violence
- Mental health and emotional well being
- Home safety/ animals/ home environment to be linked to FHNA, so not having to complete at every contact.
- If housing is adequate.
- Relationships/ Family composition/ family genogram. Who lives in the house? (Hidden Male)
- Parental childhood experiences, including mam's partner if he is not dad to children. ACE's.
- Financial/ benefits
- Employment/ training.
- Family support/ network of support
- Literacy and aspirations
- Awareness of local services and how to access them.
- Caring for family member –adults and children as carers.
- Asylum seekers
- Experience of children's social care (CIN, CP, LAC) and current involvement (parents and children)

Ideally a model that enables the FHNA and My Family Plan to be joined up will enhance the Early Help offer and evidence of the amount of early help that is delivered by 0-19 Healthier Together. Following consultation, the tool is in development and will incorporate Graded Care and Signs of Safety.

**Vulnerable Parent Pathway (VPP)**

The VPP aims to identify and intervene early with those families who are at most need of support. The pathway will look to identify parents from as early as booking using the ACE criteria as a indicator for early intervention. The pathway will be voluntary and co-delivered by the 0-19 service and stronger families

**Home Environment Assessment Tool (HEAT)**

A pilot is to be commenced in the East area, our 0-19 service is to be briefed the first week in January 2019 and then HEAT to be launched second week in January 2019.

Health Visitors to complete universally on all families by the time the child is 6-8 weeks of age and with all transfers in. School Nurses to complete with all children/ families they are working with at universal plus and universal partnership plus level, and safeguarding. 0-19 staff to document HEAT on SystmOne. Feedback sessions to be developed following pilot and then a report to be produced to inform of pilot findings.